

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14607

CERTIFICATE OF DEATH

14617

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>19 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>Petit Street</u>	
3. NAME OF DECEASED (Type or print) <u>George Washington Baine</u>		4. DATE OF DEATH Month <u>October</u> Day <u>28</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 15 1894</u>
9. AGE (In years lost birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fertilizer Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Stockton, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Noah Baine</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 12 2137</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis w/Right Hemiplegia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Hypertensive Arteriosclerotic Cardiovascular Disease.</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Month</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/9/67</u> , 19 to <u>10/28/67</u> , 19, that (I) (we) last saw the deceased alive on <u>10/28/67</u> , 19, and that death occurred at <u>5:20 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Chas. Winnacott</u>		22b. DATE SIGNED <u>10/28/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Chas. Winnacott, M.D.</u>		22d. ADDRESS <u>Box 2018 - Salisbury, Maryland - 21801</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 1, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Snow Hill, Maryland</u>	
24. FUNERAL DIRECTOR <u>Norman F. Johnson, Snow Hill, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 31 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>			

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FOR STATE  
HEALTH DEPT.

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VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Jersey</b> b. COUNTY <b>673</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Magnolia</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Regency Court, White Horse Pike</b>	
3. NAME OF DECEASED (Type or print) <b>Clarence Rudolph Bair</b>		4. DATE OF DEATH <b>10-29-67</b> 19	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-28-38</b>
9. AGE (In years last birthday) <b>29</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. <b>29</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Bair</b>		14. MOTHER'S MAIDEN NAME <b>Rose Thomas</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes Vietnam</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Record Dept. Peninsula Hospital</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>8234</b> IMMEDIATE CAUSE (a) <b>Fractured cervical spine</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in car that struck a pole.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>4:28 P.A.M. 10-29-67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway # 13</b>	20f. (City or town) (County) (State) <b>Salisbury Wicomico Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>10-29-67</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		Address (Street, city, town, or county) <b>109 Camden Ave. Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-4-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gates of Heaven Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Mt. Royal, New Jersey</b>
24. FUNERAL DIRECTOR <b>Howard C. Stevenson - Dover, Del.</b>		25a. REC'D BY REGISTRAR <b>NOV 1 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 23B, 23c, & 23d File G393 10/20/67 wk

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b> 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>xx</b>			d. STREET ADDRESS <b>RFD</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Edwin Milton Baker</b>			4. DATE OF DEATH <b>Oct. 6, 1967</b> 19		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 22, 1915</b> 52 yrs.		9. AGE (In years lost birthday) <b>52</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>House</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Willards, Md.</b>	
13. FATHER'S NAME <b>James R. Baker</b>			14. MOTHER'S MAIDEN NAME <b>Ruth Baker</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>xx xx</b>		16. SOCIAL SECURITY NO. <b>221-16-5190</b>		17. INFORMANT <b>Ruth Baker Willards, Md.</b> RFD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary</b> DUE TO (b) <b>Chr Myocard</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>10</b>	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <b>7-2-</b> , 19 <b>67</b> , to <b>8-6-</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>7-30-</b> 19 <b>67</b> , and that death occurred at <b>5:00</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>Chris R. Lane</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10-9-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <b>Bethel</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 11, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel</b>	
23d. LOCATION (City or Town) (County) (State) <b>Willards Wic. Md.</b>					
24. FUNERAL DIRECTOR <b>Peter Whaley Selbyville Del.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>OCT 13 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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14620

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD</u> 46-3		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>RURAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ARTHUR</u> Middle <u>A.</u> Last <u>BANKS</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-1-1918</u> 49 yrs.	
9. AGE (In years last birthday) <u>49</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HRDW. STORE OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HAARDWARE</u>		11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>RICHARD WARREN BANKS</u>			
14. MOTHER'S MAIDEN NAME <u>ORNA DELIGHT BANKS</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>173-10-7982</u>				17. INFORMANT <u>TRENE H. BANKS, FRANKFORD, DEL.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive head injury &amp; cerebral edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>72 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall from horse</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>11:00</u> p.m. <u>10-15</u> 1967				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>	
20f. (City or town) <u>Frankford</u>				20g. (County) <u>Del.</u>		20h. (State) <u>Del.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Philip A. Insley</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>10-18-67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-21-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CAREY'S CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>FRANKFORD, SUSSEX, DEL.</u>	
24. FUNERAL DIRECTOR <u>A. Douglas Melson, Frankford, Del.</u>				25a. REC'D BY REGISTRAR <u>OCT 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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RECEIVED FROM THE DEPT. OF THE ARMY

1-1950



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.  
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VR A15ME (J)  
6M 1/67

14611

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14621

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>		c. LENGTH OF STAY IN lb <b>Eden</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Connelly Mill Rd. Railroad Crossing</b>		d. STREET ADDRESS <b>Route # 2</b>	
3. NAME OF DECEASED (Type or print) <b>Ernest Wesley Barkley</b>		4. DATE OF DEATH <b>10-20-67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-11-37</b>
9. AGE (In years last birthday) yrs. <b>30</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RADIOMAN 2ND CLASS</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A. NAVY</b>	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ERNEST MORRIS</b>		14. MOTHER'S MAIDEN NAME <b>MABEL BARKLEY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-30-9804</b>	
17. INFORMANT <b>Shelby BARKLEY Rt 2 Box 132 Eden Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed chest</b> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of car that collided with freight train.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>11:35 P.M. 10-20-67</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>RR crossing</b>	
20f. (City or town) (County) (State) <b>Delmar Wicomico Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>10-23-67</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		23. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Memory Garden</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10-26-67</b>	
24. FUNERAL DIRECTOR <b>Lauretta Jolley</b>		25. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
25a. REC'D BY REGISTRAR <b>NOV 1 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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Box 101 10-26-27 Spring Hill Highway Station - 10000 lbs.

James M. Smith

14622

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Washington</b> 47-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>2707 Adams Mill Road N.W.</b>	
3. NAME OF DECEASED (Type or print) <b>John Dorsey Bassett</b>		4. DATE OF DEATH Month <b>October</b> Day <b>3</b> Year <b>1967</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/23/1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Bassett</b>		14. MOTHER'S MAIDEN NAME <b>Emma May McKnett</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>218-16-5105</b>	
17. INFORMANT <b>Mrs. John D. Bassett, Washington, D.C.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral metastasis</b> DUE TO (b) <b>"spindle cell carcinoma (face-skin)"</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <b>7 mos</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>metastatic carcinoma to spine</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 22, 1967</b> , to <b>Oct 2, 1967</b> that (I) (we) lost saw the deceased alive on <b>Oct 2, 1967</b> and that death occurred at <b>7:40 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John T. Bulkeley</b>		22b. DATE SIGNED <b>10-7-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>John T. Bulkeley</b>		22d. ADDRESS <b>Pine Bluff Road, Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/7/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Firemen's</b>	23d. LOCATION (City or Town) (County) (State) <b>Sharptown, Md.</b>
24. FUNERAL DIRECTOR <b>MURCE E. NEWMAN &amp; SON, Sharptown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 10 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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*Journal of Management Education* 36(7) 809-824

14613

## CERTIFICATE OF DEATH

14623

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Bridge Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ANN</b> Last <b>Bell</b>				4. DATE OF DEATH Month <b>October</b> Day <b>7</b> Year <b>1967</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 5, 1890</b>		
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Mardela, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Z. Greene</b>				14. MOTHER'S MAIDEN NAME <b>Laura V. Elliott</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-54-9834</b>		17. INFORMANT Address <b>Mrs. Lucille Donohoe (Daughter)</b> <b>624 Pine Bluff Road, Salisbury, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Occlusion of Coronary artery with</b> DUE TO <b>rupture post. Myocardium and Compensated</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <b>Arteriosclerotic Heart Disease</b> (c) <b>Yes.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 day.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myxedema, Primary</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input checked="" type="checkbox"/> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>10/7</b> , 19 <b>67</b> to <b>10/9</b> , 19 <b>67</b> , that (I) (we) saw the deceased alive on <b>10/7</b> , 19 <b>67</b> and that death occurred at <b>9:37</b> M, from causes and on the date stated above.								
22a. SIGNATURE <b>Rufus S. Gardner, Jr.</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/10/67</b>		
22c. PHYSICIAN'S NAME (Type) <b>RUFUS S. GARDNER, JR.</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>October 10, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mardela Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Mardela, Maryland</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 11 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge.</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

FORM 1

INVESTIGATION OF CRIME

100-100000

1. NAME OF SUSPECT		2. ALIAS	
3. DATE OF BIRTH		4. PLACE OF BIRTH	
5. SEX		6. RACE	
7. HEIGHT		8. WEIGHT	
9. EYES		10. HAIR	
11. COMPLEXION		12. SCARS OR TATTOOS	
13. EDUCATION		14. OCCUPATION	
15. SOCIAL SECURITY NUMBER		16. MARITAL STATUS	
17. CURRENT ADDRESS		18. PREVIOUS ADDRESSES	
19. EMPLOYMENT HISTORY		20. CRIMINAL RECORD	
21. CHARACTER REFERENCES		22. INVESTIGATOR'S COMMENTS	

1. NAME OF SUSPECT  
2. ALIAS  
3. DATE OF BIRTH  
4. PLACE OF BIRTH  
5. SEX  
6. RACE  
7. HEIGHT  
8. WEIGHT  
9. EYES  
10. HAIR  
11. COMPLEXION  
12. SCARS OR TATTOOS  
13. EDUCATION  
14. OCCUPATION  
15. SOCIAL SECURITY NUMBER  
16. MARITAL STATUS  
17. CURRENT ADDRESS  
18. PREVIOUS ADDRESSES  
19. EMPLOYMENT HISTORY  
20. CRIMINAL RECORD  
21. CHARACTER REFERENCES  
22. INVESTIGATOR'S COMMENTS



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14614

14624

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>224 West Main Street</b>	
3. NAME OF DECEASED (Type or print) <b>James Edward Bivens</b>		4. DATE OF DEATH Month <b>10</b> Day <b>29</b> Year <b>67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Apr. 8, 1910</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LABORER</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Bivens</b>		14. MOTHER'S MAIDEN NAME <b>Louvenia Mills</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-26-4659</b>	
17. INFORMANT <b>Rosie Bivens</b>		Address <b>Pocomoke, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary atherosclerosis</b> DUE TO <b>ASCD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASCD</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>years</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>409 Camden Ave. Salisbury, Md.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>10-30-67</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county)		23a. LOCATION (City or Town) (County) (State) <b>Pocomoke City, Md.</b>	
23b. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23c. DATE THEREOF <b>11-2-67</b>	
23d. NAME OF CEMETERY OR CREMATORY <b>Tindley Chapel Cem.</b>		23e. ADDRESS <b>New Church, Va.</b>	
24. FUNERAL DIRECTOR <b>James J. Jorgensen</b>		25a. REC'D BY REGISTRAR <b>NOV 2 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles J. Jorgensen</b>		25c. DATE	



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Location

Address

Office

Telephone

Teletype

221 West Main Street

Telephone General Office

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VA

Lawrence H. H.

Joseph H.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14615

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14625

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Spring Hill Road, Rt. 5</b>				d. STREET ADDRESS <b>Rt. 5, Spring Hill Road</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>WILMER</b> Middle <b>BISHOP</b> Last <b>BOWEN, SR.</b>				4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1967</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1893</b>	9. AGE (In years last birthday) yrs. <b>74</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-teacher &amp; principal</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Board of Education - Newark, Maryland</b>		11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel T. Bowen</b>				14. MOTHER'S MAIDEN NAME <b>Ella Bishop</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War I</b>		16. SOCIAL SECURITY NO. <b>213-14-1288</b>		17. INFORMANT Address <b>Mrs. Irene F. Bowen (Wife) Rt. 5, Spring Hill Road, Salisbury, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN DEATH AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				22. DATE SIGNED <b>October 24/1967</b>			
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Maryland</b>				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 25, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR ADDRESS <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25a. REC'D BY REGISTRAR DATE <b>OCT 25 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



10018

10018

UNITED STATES DEPARTMENT OF COMMERCE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

TO THE SECRETARY

FROM THE SECRETARY

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

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10018

[illegible]

# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>23-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Route # 3</b>	
3. NAME OF DECEASED (Type or print) <b>Margaret Phillips Brittingham</b>		4. DATE OF DEATH <b>10-5-67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEP. 22, 1921</b> 43 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Berkenshire Pa</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM A. PHILLIPS</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET SINGER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Mr. Harold Phillips Berlin Md</b>		Address <b>—</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>9210</b> IMMEDIATE CAUSE (a) <b>Asphyxia due to aspirated food</b> DUE TO (b) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Began choking while eating and collapsed in yard.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>10-5-67</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Own home.</b>	20f. (City or town) (County) (State) <b>Berlin Worcester Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>10-5-67</b>	
EXAMINER'S NAME (Type) <b>409 Camden Ave. Salisbury, Md.</b>		Address (Street, city, town, or county) <b>—</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10/8/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>PHILLIPS</b>	23d. LOCATION (City or Town) (County) (State) <b>BERLIN Vior. Md</b>
24. FUNERAL DIRECTOR <b>Anna A. Burbage</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
Address <b>Berlin Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>OCT 10 1967</b>			

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Washington

Department

Director

Division

Chief

Section

Technical Services

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Technical Services

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Technical Services

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14617		MEDICAL EXAMINER'S CERTIFICATE OF DEATH				14627			
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>					d. STREET ADDRESS <b>340 Barclay Street</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MINNIE</b> Middle <b>LEE</b> Last <b>BROWN</b>					4. DATE OF DEATH Month <b>October</b> Day <b>26</b> Year <b>19 67</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 4, 1894</b>		9. AGE (In years lost birthday) <b>73</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Somerset County, Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
13. FATHER'S NAME <b>James Brown McGrath</b>					14. MOTHER'S MAIDEN NAME <b>Martha Elliott</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>- - - -</b>		17. INFORMANT Address <b>Mr. Harry H. Sallac (Son-in-law)</b> <b>111 E. College Ave., Salisbury, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Congestive Heart Failure</b> <b>4200</b> DUE TO <b>Arterio Sclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Earl L. Royer</b> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b> <b>409 Camden Ave., Salisbury, Md.</b>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>October 27/1967</b> Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 28, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>					25a. REC'D BY REGISTRAR DATE <b>OCT 30 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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but I thought that  
you would like it

Bill

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14618

CERTIFICATE OF DEATH

14628

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ELIZABETH</b> Middle <b>Post</b> Last <b>Bruehl</b>		4. DATE OF DEATH Month <b>October</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 17, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	9. AGE (In years lost birthday) yrs. <b>73</b>
11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HIRAM POST</b>		14. MOTHER'S MAIDEN NAME <b>STATIRA COOKMAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>216-14-2688</b>	
17. INFORMANT <b>Mrs John T. Bruehl</b>		Address <b>Berlin Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery Thrombosis</b> DUE TO (b) <b>Coronary Atherosclerosis</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept. 12, 1967</b> to <b>Oct. 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct. 23, 1967</b> , and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Hand J. Gilmore</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10/26/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>	23d. LOCATION (City or Town) (County) (State) <b>BERLIN WOR. MD</b>
24. FUNERAL DIRECTOR <b>Anna A. Burbage</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 25 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14629

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Berlin</b> 23.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>North Main Street</b>	
3. NAME OF DECEASED (Type or print) <b>Ernest E. Burbage Jr.</b>		4. DATE OF DEATH Month <b>10</b> Day <b>1</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 23 1910</b>
9. AGE (In years lost birthday) yrs. <b>57</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED MERCHANT STORE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>STORE</b>	
11. BIRTHPLACE (State or foreign country) <b>BERLIN MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ERNEST E. BURBAGE SR</b>		14. MOTHER'S MAIDEN NAME <b>MARY JANE PURNELL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mr HARLAN BURBAGE BERLIN MD</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>10-2-67</b>	
EXAMINER'S NAME (Type) <b>409 Camden Ave. Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10/4/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BUCKINGHAM</b>	23d. LOCATION (City or Town) (County) (State) <b>BERLIN WOR. MD</b>
24. FUNERAL DIRECTOR <b>Anna A. Burbage Berlin Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 5 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

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ATTORNEY GENERAL'S OFFICE

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## CERTIFICATE OF DEATH

14630

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>BERLIN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>POWELLTON Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>SADIE</b> First Middle Last <b>CAREY</b>		4. DATE OF DEATH Month <b>October</b> Day <b>22</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-5-1885</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Worcester Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>CHARLES BAKER</b>		14. MOTHER'S MAIDEN NAME <b>MARY RICHARDSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>217-03-604</b>	
17. INFORMANT <b>MRS. Rada Esham</b>		Address <b>Berlin, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral femoral arterial occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriosclerotic Heart disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 16</b> , 19 <b>67</b> to <b>Oct 22</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-22</b> , 19 <b>67</b> , and that death occurred at <b>9P.</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Sam J. B. [Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>OCTOBER 25</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		23d. LOCATION (City or Town) (County) (State) <b>BERLIN WORCESTER Md.</b>	
24. FUNERAL DIRECTOR <b>Anna A. Burbage Berlin Md.</b>		25a. REC'D BY REGISTRAR <b>DATE OCT 30 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10000

CERTIFICATE OF DEATH

Location

Collector

Deceased's General Location

10000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

14621		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		14631	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>4 mos - 8 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>/Chesapeake City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>			d. STREET ADDRESS <b>Box 52</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Milton Fletcher Charsha</b>			4. DATE OF DEATH Month <b>October</b> Day <b>28</b> Year <b>19 67</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-97</b>	9. AGE (In years lost birthday) <b>70</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. SHOVEL OPER.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>CONST.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>COLORA, IND.</b>	
13. FATHER'S NAME <b>OLIVER C. CHARSHA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>258-10-6454</b>		17. INFORMANT <b>LAURENCE R. CHARSHA</b> Address <b>CHESAPEAKE CITY, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>331X</b> IMMEDIATE CAUSE (a) <b>CVA - Rt. Hemiplegia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bilateral Prostate Hypertrophy</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6-7 mos.</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>June 21, 1967</b> , to <b>Oct. 28, 1967</b> , that (I) (we) last saw the deceased alive on <b>October 28, 1967</b> , and that death occurred <b>1125P M.</b> from causes and on the date stated above.					
22a. SIGNATURE <b>C. H. Winnacott</b>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/29/67</b>
22c. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M.D.</b>			22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-1-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>BETHEL</b>		23d. LOCATION (City or Town) (County) (State) <b>CHESAPEAKE CITY, MD.</b>
24. FUNERAL DIRECTOR <b>PIPPIN FUNERAL HOME</b>			25a. REC'D BY REGISTRAR <b>Robert [Signature]</b>		25b. REGISTRAR'S SIGNATURE <b>Charles [Signature]</b>

OCT 31 1967



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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>Mearsville, Va</u>	
3. NAME OF DECEASED (Type or print) <u>Doris</u> First <u>Doris</u> Middle <u>Chase</u> Last		4. DATE OF DEATH <u>October 11</u> 19 <u>67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 17, 1903</u> 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>63</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Mearsville, Accomack, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Carl F. Davis</u>		14. MOTHER'S MAIDEN NAME <u>Annie Byrd</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>227-38-5813</u>	
17. INFORMANT <u>Waldon Chase, Mearsville, Va.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>Not Known</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/10/67</u> to <u>10/11/67</u> , that (I) (we) last saw the deceased alive on <u>10/11/67</u> and that death occurred at <u>5 P.M.</u> from causes on and the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE <u>[Signature]</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Wendell Thornton</u>		22d. ADDRESS <u>Partokely, Va</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-14-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bittel church yard</u>	23d. LOCATION (City or Town) (County) (State) <u>Blotom, Va.</u>
24. FUNERAL DIRECTOR <u>Thorton Funeral Home</u>		25a. REC'D BY REGISTRAR <u>DATE OCT 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
c. LENGTH OF STAY IN lb <b>2 mons.</b>		d. STREET ADDRESS <b>Spring Hill Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wicomico Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ERNEST * CHURCH</b>		4. DATE OF DEATH Month Day Year <b>October 5 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 31, 1881</b>
9. AGE (In years lost birthday) yrs. <b>83</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Minister Ret.</b>	
10b. KIND OF BUSINESS OR INDUSTRY <b>Baptist</b>		11. BIRTHPLACE (County & State, or foreign country) <b>England</b>	
12. CITIZEN OF WHAT COUNTRY? <b>Unknown</b>		13. FATHER'S NAME <b>Unknown</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No -</b>	
16. SOCIAL SECURITY NO. <b>211-24-2665</b>		17. INFORMANT <b>William A. Harris Jr., Snow Hill, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Disease</b> DUE TO (b) <b>Atherosclerosis</b> DUE TO (c) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Mar 17 19 67</b> to <b>10/5 19 67</b> that (I) (we) last saw the deceased alive on <b>19</b> , and that death occurred at <b>M</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>W B Smith</b> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>10/6/67</b>
22c. PHYSICIAN'S NAME (Type) <b>William Smith MD</b>		22d. ADDRESS <b>Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/7/1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Spence Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Rural Snow Hill, Md.</b>
24. FUNERAL DIRECTOR <b>Gerald C. Sound</b> Snow Hill, Md.		25a. REC'D BY REGISTRAR DATE <b>OCT 9 1967</b>	25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Lunes</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> 41-3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R D 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joyce E ANN Coggin</u>				4. DATE OF DEATH Month Day Year <u>October 18 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26, 1943</u>		9. AGE (In years last birthday) yrs. <u>24</u>	IF UNDER 1 YEAR Months Days Hours Min. <u>18</u> <u>18</u> <u>18</u> <u>18</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John A Lorette</u>				14. MOTHER'S MAIDEN NAME <u>Christine Anderson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-38-9674</u>		17. INFORMANT <u>Ruffin Coggin</u>		Address <u>Delmar Del</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myeloblastic Leukemia</u> 2041 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from <u>Sept 13, 1967</u> to <u>Oct 18, 1967</u> that (I) (we) saw the deceased alive on <u>Oct 18, 1967</u> , and that death occurred at <u>1:00</u> P.M. from causes and on the date stated above.							
22a. SIGNATURE <u>Thomas C. Hill Jr.</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas C. Hill Jr.</u>				22d. ADDRESS <u>Pine Bluff Road, Salisbury Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Springside Memory Garden</u>		23d. LOCATION (City or Town) (County) (State) <u>Salisbury Newmar Md.</u>	
24. FUNERAL DIRECTOR <u>William S. Moad</u>				ADDRESS <u>Delmar Del</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
				DATE <u>OCT 23 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14625

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>17 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>			d. STREET ADDRESS <b>435 South Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Pauline Virginia Conway</b>			4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1924</b>	9. AGE (In years last birthday) yrs. <b>43</b>	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Queen Anne County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Henry Smallwood</b>			14. MOTHER'S MAIDEN NAME <b>Clara Pauls</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	17. INFORMANT Address <b>Clara P. Wilmer, Wye Mills, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of cervix with generalized metastasis</b> DUE TO (b) <b>171X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>9/18</b> , 19 <b>67</b> , to <b>10/5</b> , 19 <b>67</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>10/5</b> , 19 <b>67</b> , and that death occurred at <b>1:45 P.M.</b> , from causes and on the date stated above.					
22a. SIGNATURE <i>L.V. Maldve</i>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>10/5/67</b>
22c. PHYSICIAN'S NAME (Type) <b>L.V. Maldve, M.D.</b>			22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/9/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Newtown</b>	23d. LOCATION (City or Town) (County) (State) <b>Cordova, Talbot co., Md.</b>		
24. FUNERAL DIRECTOR ADDRESS <b>Barbara L. Dashiell Easton, Maryland</b>			25a. RECEIVED BY REGISTRAR DATE <b>OCT 11 1967</b>	25b. REGISTRAR'S SIGNATURE <i>J. Charles Juge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14628		14636	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Easton</b>	
c. LENGTH OF STAY IN TB <b>1 mo. 4 days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Rt. #2 (Black Dog Alley)</b>	
3. NAME OF DECEASED (Type or print) <b>Arthur Elliott Cook</b>		4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/4/1901</b>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		9b. KIND OF BUSINESS OR INDUSTRY	
10. BIRTHPLACE (County & State, or foreign country) <b>Queen Anne, Maryland</b>		11. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
12. FATHER'S NAME <b>Joseph Cook</b>		13. MOTHER'S MAIDEN NAME <b>Mamie Elloit</b>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		15. SOCIAL SECURITY NO. <b>220-32-1421</b>	
16. INFORMANT <b>Mrs. Sarah Marie Cook, RFD #2, Easton, Md.</b>		17. ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lipo-Sarcoma Left Chest with Extensive Pulmonary Metastases</b> 1971 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>September 25, 1967</b> , to <b>Oct. 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct. 29, 1967</b> , and that death occurred at <b>7:00 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Winnacott</b>		22b. DATE SIGNED <b>10/29/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. WINNACOTT, M.D.</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/1/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Easton, Md.</b>
24. FUNERAL DIRECTOR <b>Jay D. Housh, Easton, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 1 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



## CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>WICOMICO</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b <b>SHARPTOWN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>456 NANTICOKE STS.</b>			
3. NAME OF DECEASED (Type or print) <b>WALTER HENRY CORDREY</b>				4. DATE OF DEATH <b>October 25 19 67</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/5/1914</b>	9. AGE (In years last birthday) <b>52</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TYPE-COVERER-INSULATION-DUPONT</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SUSSEX, DEL.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>
13. FATHER'S NAME <b>ARTHUR CORDREY</b>				14. MOTHER'S MAIDEN NAME <b>WINNIE HENRY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-03-4716</b>		17. INFORMANT Address <b>MRS. WALTER H. CORDREY, SHARPTOWN, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Ventricular Fibrillation due to</b> DUE TO (b) <b>Arteriosclerotic Heart Disease and</b> DUE TO (c) <b>Old Myocardial Infarction</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 20, 1967</b> to <b>Oct 25, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 8, 1967</b> , and that death occurred at <b>5:12 M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Thomas C. Hill Jr.</b>				22b. DATE SIGNED <b>10-27-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Pine Bluff Road, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/28/1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FIREMEN'S</b>		23d. LOCATION (City or Town) (County) (State) <b>SHARPTOWN MD</b>	
24. FUNERAL DIRECTOR <b>NEWYAM FUNERAL HOME, SHARPTOWN, MD</b>				25a. REC'D BY REGISTRAR <b>OCT 31 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)  
25M 1/67

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Ridge Road</b>	
3. NAME OF DECEASED (Type or print) <b>Helen</b> First Middle Last <b>Cornish</b>		4. DATE OF DEATH Month <b>10</b> Day <b>13</b> Year <b>19 67</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/10/10</b>
9. AGE (In years last birthday) yrs. <b>57</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13. FATHER'S NAME <b>Daniel Cornish</b>		14. MOTHER'S MAIDEN NAME <b>Julia Tull</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Howard Cornish, Princess Anne, Md</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of the right breast with wide spread metastasis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)			
<b>Status post adrenalectomy</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour :o.m. :p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if (this hospital) attended the deceased from <b>October 3, 1967</b> to <b>October 13, 1967</b> , that (we) last saw the deceased alive on <b>October 13, 1967</b> , and that death occurred at <b>10:45 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve</b>		22b. DATE SIGNED <b>10/16/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/16/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Zion</b>	23d. LOCATION (City or Town) (County) (State) <b>Polk Road, S.Md</b>
24. FUNERAL DIRECTOR <b>William H. James Jr. Princess Anne, Md</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

CERTIFICATE OF DEATH

14628

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RECEIVED

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TO THE HONORABLE SECRETARY OF THE  
NAVY  
WASHINGTON, D. C.  
SIR:  
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above subject.  
The same has been forwarded to the proper authorities for their consideration.  
Very respectfully,  
Your obedient servant,  
J. M. Smith  
Acting Secretary

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14629

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14639

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>13 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>RFD</b>	
3. NAME OF DECEASED (Type or print) <b>Granville S Cropper</b>		4. DATE OF DEATH Month <b>10</b> Day <b>29</b> Year <b>67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-9-71</b>
9. AGE (In years last birthday) <b>96</b> yrs.		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Mail</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles W. Cropper</b>		14. MOTHER'S MAIDEN NAME <b>Ann Kathryn Gray</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>XX XX</b>		16. SOCIAL SECURITY NO. <b>214-34-8238</b>	
17. INFORMANT <b>Della Cropper</b>		Address <b>Bishopville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Branch pneumonia</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fracture of Pelvis</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell at own home.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>9A.M. 10-16-67</b>		20d. INJURY OCCURRED <input checked="" type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Own home.</b>		20f. (City or town) (County) (State) <b>Bishopville Worcester Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		22. DATE SIGNED <b>10-30-67</b>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		Address (Street, city, town, or county) <b>109 Camden Ave. Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-11-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Old Fellows</b>		23d. LOCATION (City or Town) (County) (State) <b>Bishopville, Md.</b>	
24. FUNERAL DIRECTOR <b>Peter Whaley Seligman</b>		25a. REC'D BY REGISTRAR <b>NOV 6 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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## CERTIFICATE OF DEATH

14640

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>103 East Street</b>	
3. NAME OF DECEASED (Type or print) <b>JANE TERESA DELANO</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 17 1888</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months <b>7</b> Days <b>17</b> IF UNDER 24 HRS. Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Timothy Foley</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-48-1540</b>	
17. INFORMANT <b>Harold K. Delano</b>		Address <b>Delmar MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>ASCVD DISEASE</b> DUE TO (c) <b>INDEF.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>4 HRS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>CHOLEDOCHOLETHIASIS</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/4</b> , 1967 to <b>10/4</b> , 1967, that (I) (we) last saw the deceased alive on <b>10/4</b> , 1967, and that death occurred at <b>3:55 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John M. Bloxom III</b>		22b. DATE SIGNED <b>10/4/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>JOHN M. BLOXOM</b>		22d. ADDRESS <b>MEDICAL CENT. SALISBURY, MD</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/7/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Springhill Memory Garden</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury Wicomico MD</b>
24. FUNERAL DIRECTOR <b>William M. Ward</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 9 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF MICHIGAN

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14631

CERTIFICATE OF DEATH

14641

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>403 Mount Street</b>	
3. NAME OF DECEASED (Type or print) <b>Orlie CLEVELAND Dennis</b>		4. DATE OF DEATH <b>October 16 1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 25, 1885</b>
9. AGE (In years last birthday) <b>82 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Worcester County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Purnell J. Dennis</b>		14. MOTHER'S MAIDEN NAME <b>Alice Hudson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-54-5343</b>	
17. INFORMANT <b>Mrs. Alice K. Brittingham (Daughter)</b>		Address <b>403 Mount Street, Salisbury, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs (approx)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cerebral Arteriosclerosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>67</b> , to <b>Oct. 15</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Oct. 15 1967</b> , and that death occurred at <b>3A</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED <b>Oct. 16, 1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>DAVID J. GILMORE</b>		22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 18, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

11011

CERTIFICATE OF DEATH

11011



NO. 11011 OF 1911  
This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the Registrar of Births and Deaths for the District of ...



CERTIFICATE OF DEATH

14642

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Wicomico Nursing Home</b>				d. STREET ADDRESS <b>Fruitland</b> <b>Dulany Ave. &amp; Cedar St.</b>			
3. NAME OF DECEASED (Type or print) First <b>LILLIE</b> Middle <b>MAY</b> Last <b>ENNIS</b>				4. DATE OF DEATH Month <b>October</b> Day <b>10</b> Year <b>1967</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>Sept. 24, 1882</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired employee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Food Processing Co.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joseph Henry Tilghman</b>				14. MOTHER'S MAIDEN NAME <b>Alice Vincent</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-05-8702A</b>		17. INFORMANT Address <b>Mr. Arthur J. Ennis (Son)</b> <b>P.O. Box #97, Fruitland, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4221</b> DUE TO <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Myeloid Leukemia</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 months</b> <b>7</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan App. 1961</b> to <b>10/10/1967</b> , that (I) (we) last saw the deceased alive on <b>10/10/1967</b> , and that death occurred at <b>4:10 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert T. Adkins</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>October 12/1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Robert T. Adkins</b>				22d. ADDRESS <b>Fruitland, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 13, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Union Church Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 13 1967</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14633

CERTIFICATE OF DEATH

14643

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>46-3</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DELAWARE</b> b. COUNTY <b>Sussex</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Near Columbia</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HESTER ESTHER GAINES</b>		4. DATE OF DEATH <b>October 29 1967</b>		5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-18-1888</b>		9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Delmar, Delaware</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Games</b>				14. MOTHER'S MAIDEN NAME <b>Easter Games</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Russell Gaines, Delmar, Del., RFD #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>332x</b> IMMEDIATE CAUSE (a) <b>Renal Failure - due to</b> DUE TO (b) <b>Arteriosclerosis and Diabetes</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Arteriosclerosis with old Thrombosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>Oct 26, 1967</b> to <b>Oct 29, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 29, 1967</b> , and that death occurred at <b>1:35 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Thomas C. Hill Jr.</b>		22b. DATE SIGNED <b>10-29-67</b>		22c. PHYSICIAN'S NAME (Type) <b>THOMAS C. HILL JR.</b>		22d. ADDRESS <b>Pine Bluff Road, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 2, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Nebo Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Delmar, Delaware</b>	
24. FUNERAL DIRECTOR <b>J. J. Frampton and Son, Federalburg, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 2 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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CENTRAL OF GEORGIA

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Items #8 & 9 Film #A395 32 A/67

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) e. STATE <i>MARYLAND</i>		b. COUNTY <i>Worcester</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Dalisbury</i>		c. LENGTH OF STAY IN lb <i>4 wks</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>403 West. Market Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Wicomico County Nursing Home</i>		d. STREET ADDRESS <i>Snow Hill Maryland</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Matilda</i>		First <i>Matilda</i>		Middle <i>Gillette</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Nov. 15 1886</i>		9. AGE (In years last birthday) <i>79</i>		10. IF UNDER 1 YEAR Months <i>10</i> Days <i>22</i> Hours <i>19</i> Min. <i>67</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Stockton</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>George Spencer</i>		14. MOTHER'S MAIDEN NAME <i>Jenny</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <i>219-05-0354</i>		17. INFORMANT <i>MARY GANT - 405 Market St. Snow Hill, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4220</i> DUE TO <i>congestive heart failure</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <i>degenerative heart disease</i> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>fracture of hip, pneumonia left breast.</i>		INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>yes.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>pm</i> <i>19</i>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/5</i> , 19 <i>67</i> to <i>10/22</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10/22</i> , 19 <i>67</i> , and that death occurred at <i>7 PM</i> , from the causes and on the date stated above.		22a. SIGNATURE <i>John H. Hurdley</i>		22b. DATE SIGNED <i>10/27/67</i>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>10-29-67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Collins Temple</i>	
23d. LOCATION (City, town or county) (State) <i>Snow Hill Md.</i>		24. FURNERAL DIRECTOR <i>Louella B. Jolley</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25c. DATE <i>NOV 2 1967</i>		25d. ADDRESS	

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*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "1941" and "1942" are visible.]*

## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Wicomico</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN Tb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Delmar</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>				d. STREET ADDRESS <b>Rd 3</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>MARY GRACE GREEN</b>				4. DATE OF DEATH Month Day Year <b>October 13 1967</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct 14, 1900</b>	
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.</b>	
13. FATHER'S NAME <b>Stanley R. Green</b>				14. MOTHER'S MAIDEN NAME <b>Veronica Rubles</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>321-32-4309</b>		17. INFORMANT Address <b>Mr Basil Parson Delmar, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Embolism, Pulmonary Arterial</b> <b>434.4</b> DUE TO <b>Mural Thrombosis of heart</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <b>Hypertrophy and Dilatation of heart</b> (b) <b>yes</b> (c) <b>yes</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1-2 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus; Obesity; Thyroid Adenoma</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/12</b> , 19 <b>67</b> , to <b>10/13</b> , 19 <b>67</b> , that (I) (we) lost saw the deceased alive on <b>10/13</b> , 19 <b>67</b> , and that death occurred at <b>8:15</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Professor Gardner Jr</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/14/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RUFUS S GARDNER JR</b>				22d. ADDRESS <b>MEDICAL CENTER, SALISBURY, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nelson Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Delmar Wicomico Md</b>	
24. FUNERAL DIRECTOR <b>William M. Mory</b>				ADDRESS <b>Delmar, Del.</b>		25a. REC'D BY REGISTRAR <b>Oct 11 1967</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1-18-15

CERTIFICATE OF DEATH

1-18-15

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# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
Item #7 Film #G394 11/7/67 ph											
14635						14646					
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>				c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Princess Anne</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS <b>Route # 3 Box 322</b>				19-2	
3. NAME OF DECEASED (Type or print) <b>Edna Louise Hall</b>						4. DATE OF DEATH <b>10-25-67</b>		Month <b>10</b> Day <b>25</b> Year <b>19</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-19-42</b>		9. AGE (In years lost birthday) yrs. <b>25</b>		IF UNDER 1 Year Months <b>25</b> Days <b>25</b> Hours <b>25</b> Min. <b>25</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Wallace White</b>						14. MOTHER'S MAIDEN NAME <b>Emma Woolford</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>191-38-0109</b>		17. INFORMANT <b>Oliver Hall</b>				Address <b>Princess Anne Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> <b>7546</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>Stricture of the abdominal aorta</b>										INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Patient expired under anesthesia for aortic bypass.</b>										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
22. ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>409 Camden Ave. Salisbury, Md.</b>						22. DATE SIGNED <b>10-27-67</b> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10/29/ 67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church</b>		23d. LOCATION (City or Town) (County) (State) <b>Venton Somerset Md.</b>			
24. FUNERAL DIRECTOR <b>Clinton F. Stewart</b>						25a. REC'D BY REGISTRAR <b>NOV 3 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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14637

## CERTIFICATE OF DEATH

14647

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE <b>MARYLAND</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ocean City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>FRANCIS MAYLOR HARMESON</b>		4. DATE OF DEATH <b>October 21, 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 22 1910</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RECOUNTANT</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>REALTOR</b>	11. BIRTHPLACE (County & State, or foreign country) <b>ILLINOIS</b>
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>342-05-5664</b>	17. INFORMANT <b>MR. ROBERT BOWNERS</b> Address <b>Ocean City Md.</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Failure</b> DUE TO (b) <b>Inanition</b> DUE TO (c) <b>Multiple Metastatic Malignancy</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 Mos</b> <b>5 Yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-12, 1967</b> to <b>10-21, 1967</b> , that (I) (we) lost saw the deceased alive on <b>10-21, 1967</b> , and that death occurred at <b>11:55 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Frank E Poole, M.D.</b>		22b. DATE SIGNED <b>10-21-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank E Poole, M.D.</b>		22d. ADDRESS <b>111 Davis St Salisbury Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>RIVERSIDE</b>	23d. LOCATION (City or Town) (County) (State) <b>BERLIN WOr. MD</b>
24. FUNERAL DIRECTOR <b>Anne A. Burbage</b> ADDRESS <b>Berlin Md</b>		25a. REC'D BY REGISTRAR <b>OCT 26 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

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## CERTIFICATE OF DEATH

14638

14648

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Wicomico Nursing Home</b>		d. STREET ADDRESS <b>8 Somerset Avenue</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Marguerite Geneva Harrison</b>		4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 4, 1878</b>
9. AGE (In years lost birthday) yrs. <b>89</b>		IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Accomack County, Virginia</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Dennis Hart</b>	
14. MOTHER'S MAIDEN NAME <b>Susan Killmon</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Orville C. Harrison, Pocomoke City, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>4200</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug 17, 19 67</b> to <b>Oct 1, 19 67</b> that (I) (we) last saw the deceased alive on <b>Sept. 29, 19 67</b> and that death occurred at <b>8:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Gilmore</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>David J. Gilmore, M.D.</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-4-1967</b>	23c. NAME OF CEMETERY OR CREMATOR <b>First Baptist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City-Wor.-Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>OCT 5 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THE UNIVERSITY OF CHICAGO

1933

STATEMENT OF DEBIT

1933

DATE		DESCRIPTION		AMOUNT	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14639 Item #8 Film #G394 11/13/67 ph									
CERTIFICATE OF DEATH									
14649									
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishopville</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>					d. STREET ADDRESS <b>23-3</b>				
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>W.</b> Last <b>Hickman</b>					4. DATE OF DEATH Month <b>October</b> Day <b>30</b> Year <b>1967</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1896</b> <b>Oct. 6, 1967</b>		9. AGE (In years last birthday) <b>71</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Pemberton Hickman</b>					14. MOTHER'S MAIDEN NAME <b>Anna Bunting</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>xx</b>			16. SOCIAL SECURITY NO. <b>xx</b>		17. INFORMANT <b>Louis Hickman Ocean City, Md.</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> <b>456x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Coronary Vascular Disease</b> DUE TO (c) <b>Pericarditis suspected</b>								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>10-30</b> , 1967, to <b>10-30</b> , 1967, that (I) (we) last saw the deceased alive on <b>10-30</b> , 1967, and that death occurred at <b>12 PM</b> , from causes and on the date stated above.									
22a. SIGNATURE <b>Joseph C. Fitzgerald</b>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-3-67</b>		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL, etc. <b>REMOVED</b>		23b. DATE THEREOF <b>11/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows</b>			23d. LOCATION (City or Town) (County) (State) <b>Bishopville</b>		
24. FUNERAL DIRECTOR <b>Peter Whaley Salisbury Md.</b>					25a. REC'D BY REGISTRAR DATE <b>NOV 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

*(continued)*

100

Spring Spring



## CERTIFICATE OF DEATH

14640

14650

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>HEBRON - RT 1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>RT 1-Box 142</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>A</b> Last <b>Holt SA</b>		4. DATE OF DEATH Month <b>October</b> Day <b>17</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-22-1906</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SEAMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maritime</b>	9. AGE (In years last birthday) yrs. <b>60</b>
13. FATHER'S NAME <b>Albert Holt</b>		11. BIRTHPLACE (County & State, or foreign country) <b>BALTO - MD</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>Mrs Lois Ection - RT 1-Box 142 Hebron Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>with old myocardial Infarction</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour, a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Feb.</b> , 19 <b>67</b> to <b>Oct 17</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Oct 17</b> , 19 <b>67</b> , and that death occurred at <b>195</b> M, from causes on and the date stated above.			
22a. SIGNATURE <b>Thomas C. Hill Jr.</b>		22b. DATE SIGNED <b>10-17-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Thomas C. Hill Jr.</b>		22d. ADDRESS <b>Pine Bluff Road, Salisbury Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10-20-67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>Glen Burnie Md</b>
24. FUNERAL DIRECTOR <b>Thomas J. Kennedy 1600 Hollins</b>		25a. REC'D BY REGISTRAR <b>ACT 18 1967</b>	25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CENTRAL BANK

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14641

## CERTIFICATE OF DEATH

14651

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural-Pocomoke City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>R.F.D. 2</b>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>LENA</b> Last <b>Hudson</b>		4. DATE OF DEATH Month <b>October</b> Day <b>29</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 9, 1889</b>
9. AGE (In years last birthday) yrs. <b>78</b>		10. IF UNDER 1 YEAR: Months <b>29</b> Days <b>29</b> Hours <b>19</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Worcester County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Ward</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Robertson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Elmer B. Hudson, Pocomoke City, Md.</b>		Address <b>R.F.D. 2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia</b> DUE TO (b) <b>Paracetamol &amp; penicillin</b> DUE TO (c) <b>2 mo.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Cholelithiasis &amp; cdc 9-14-67</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9-4</b> , 19 <b>67</b> to <b>10-29</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-28</b> 19 <b>67</b> , and that death occurred at <b>5:42</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Nevins W. Todd</b>		22b. DATE SIGNED <b>10-31-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Nevins W. Todd, M.D.</b>		22d. ADDRESS <b>Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-1-1967</b>	23c. NAME OF CEMETERY OR INTERMENT <b>Goodwill Methodist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City - Wor. -Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>NOV 3 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

1997

2321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14642

CERTIFICATE OF DEATH

14652

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>22 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>728 E. Church Street</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Fitzhugh Lee Insley, Sr.</b>		4. DATE OF DEATH Month Day Year <b>October 17 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3, 1885</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years lost birthday) yrs. <b>82</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Bivalve, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Dallas Insley</b>		14. MOTHER'S MAIDEN NAME <b>Susan Horseman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-7879</b>	
17. INFORMANT <b>Mr. F. L. Insley, Jr. (Son)</b> <b>801 Alvin Ave., Salisbury, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Tracheo-bronchitis</b> DUE TO (b) <b>Bilateral bronchopneumonia</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>1 week</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Adenocarcinoma of prostate</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from <b>9/25</b> , 19 <b>67</b> , to <b>10/17</b> , 19 <b>67</b> , that (X) (we) lost the deceased alive on <b>10/17</b> , 19 <b>67</b> , and that death occurred at <b>11:15 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve</b>		22b. DATE SIGNED <b>10/17/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 20, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Maryland</b>
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 20 1967</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

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2:5

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Item #1b & d Film #G-94 11/3/67 ph									
14643									
14653									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Purnell Street</u>					d. STREET ADDRESS <u>Purnell St. R.F.D. Jersey Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Clarence Jenkins</u>					4. DATE OF DEATH Month <u>10</u> - Day <u>22</u> - Year <u>1967</u>				
5. SEX <u>M</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-3-1883</u>		9. AGE (In years lost birthday) <u>84</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Yard Empl.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Winnboro S.C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Cyrus Jenkins</u>					14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>225-42-6848A</u>		17. INFORMANT <u>Lillie Wise</u> Address <u>Purnell St. Jersey Rd. RFD Salisbury, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic Heart Disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>Indefinite</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>20 Oct.</u> , 19 <u>67</u> , to <u>23 Oct.</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>23 Oct.</u> , 19 <u>67</u> , and that death occurred at <u>3:00</u> M., from causes and on the date stated above.									
22a. SIGNATURE <u>Purnell</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>26 Oct 67</u>		
22c. PHYSICIAN'S NAME (Type) <u>E.A. Purnell, MD</u>					22d. ADDRESS <u>652 W Main Salisbury, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-26-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREEN ACRES</u>			23d. LOCATION (City or Town) (County) (State) <u>Salisbury Md - Md.</u>		
24. FUNERAL DIRECTOR <u>Loretta B. Jolley - Jersey Rd. Salisbury Md.</u>					25a. REC'D BY REGISTRAR DATE <u>OCT 30 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

James A. Jones - President, Seafarers

10-25-67 Green Acres

22-10-1905 Lillie Wise  
House of Unemployment  
Baltimore, Md.  
Unknown  
Maryland Engr. Wm. D. C. 20  
U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
20 M 1/66

Item #8 Film #G391 11/15/67 ph

CERTIFICATE OF DEATH

14644

16142

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MT. VERNON</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>E.</b> Last <b>JONES</b>		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>30</b> Year <b>1967</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1897</b> <b>4-10-1897</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FACTORY WORKER</b>		11. BIRTHPLACE (County & State, or foreign country) <b>DENTON CAROLINE, MD</b>	
13. FATHER'S NAME <b>FREDRICK RICH</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-01-2458</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Arteriosclerotic Hypertension</b> DUE TO (c) <b>heart disease</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/30, 1967</b> to <b>10/30, 1967</b> that (I) (we) last saw the deceased alive on <b>10/30, 1967</b> and that death occurred at <b>12 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>David J. Wilson</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>William H. James III</b>		25a. REC'D BY REGISTRAR <b>NOV 10 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>James H. Jones</b>		25c. REGISTRAR'S SIGNATURE	

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CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>318 Cherryway</b>	
3. NAME OF DECEASED (Type or print) <b>Paul Scott Jones</b>		4. DATE OF DEATH Month <b>October</b> Day <b>6</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 7, 1907</b>
9. AGE (In years last birthday) yrs. <b>60</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Timber</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Eleck Jones</b>		14. MOTHER'S MAIDEN NAME <b>Ida Downs</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>XX XX</b>		16. SOCIAL SECURITY NO. <b>222-09-7877</b>	
17. INFORMANT <b>Josh Jones</b>		Address <b>Salisbury, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Lung</b> DUE TO (b) <b>metastases to adrenal</b> DUE TO (c) <b>?</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>3 wks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Eczema</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 21, 1967</b> to <b>Oct 6, 1967</b> , that (I) (we) last saw the deceased alive on <b>Oct 6, 1967</b> , and that death occurred at <b>7:40 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>John S. Bulkeley</b> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>10/10/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Dale</b>	23d. LOCATION (City or Town) (County) (State) <b>Whaleyville Worcester</b>
24. FUNERAL DIRECTOR <b>Peter Whaley</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 16 1967</b>	
ADDRESS <b>Salisbury, Del.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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DEPARTMENT OF HEALTH

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## CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> o. STATE <b>MARYLAND</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>21-2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>104 S. MAIN</b>	
3. NAME OF DECEASED (Type or print) <b>WALTER MERRITT KENLY</b>		4. DATE OF DEATH <b>October 18 1967</b>	
5. SEX <b>M.</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>POULTRY INSPECTOR</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POULTRY</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>BALTIMORE MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALBERT CLARK KENLY</b>		14. MOTHER'S MAIDEN NAME <b>LILIAN MILLER</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WALDO WAD</b>	
17. INFORMANT <b>Mrs WALTER M. KENLY</b>		Address <b>Berlin MD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal obstruction</b> DUE TO <b>Carcinoma rectum</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <b>Cardiovascular and disease</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>6-10, 1967</b> to <b>10-18, 1967</b> , that (I) (we) last saw the deceased alive on <b>10-17, 1967</b> , and that death occurred at <b>4:52 AM</b> , from causes on and on the date stated above.			
22a. SIGNATURE <b>Ph. L. P. A. Insley</b>		22b. DATE SIGNED <b>10-19-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Ph. L. P. A. Insley</b>		22d. ADDRESS <b>Salisbury Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>10 20 67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. PAULS</b>	23d. LOCATION (City or Town) (County) (State) <b>BERLIN WOR MD</b>
24. FUNERAL DIRECTOR <b>Anne A. Burboze</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE		DATE <b>OCT 23 1967</b>	

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## CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>SOMERSET</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>PRINCESS ANNE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>193</b>	
3. NAME OF DECEASED (Type or print) <b>Robert</b> First Middle Last <b>LAIRD</b>		4. DATE OF DEATH Month <b>October</b> Day <b>12</b> Year <b>1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-14-38</b>
9. AGE (In years lost birthday) <b>28</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABOR</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>MT. VERNON, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CLIFTON LAIRD</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH BLOODSWORTH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-36-1187</b>	
17. INFORMANT <b>MRS CLIFTON LAIRD PRINCESS ANNE, MD.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia</b> <b>592X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Chronic glomerular nephritis</b> (c) <b>not known</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Hypertensive Heart disease</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/4/67</b> to <b>10/12/67</b> , that (I) (we) lost the deceased on <b>10/14/67</b> , and that death occurred at <b>4:40</b> P.M. from causes on and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>[Signature]</b>		22d. ADDRESS M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/16/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ASBURY CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MT. VERNON, MD.</b>	
24. FUNERAL DIRECTOR <b>LEVIN R. WILSON PRINCESS ANNE, MD.</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14657

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>429 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>203 Linden Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>HUGH</b> Last <b>LONG</b>		4. DATE OF DEATH Month <b>10</b> Day <b>27</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1897</b>
9. AGE (In years lost birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Somerset County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Woodland A. Long</b>		14. MOTHER'S MAIDEN NAME <b>Lola Emma Gibbons</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-36-0013</b>	
17. INFORMANT <b>Mrs Rose Long, Pocomoke City, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>442X</b> DUE TO <b>Hypertensive Arteriosclerotic Cardiovascular</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Renal Disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 to 7 days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>1. Broncho pneumonia (several days) 2. Chronic Gout</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>August 24</b> , 19 <b>66</b> , to <b>October 27, 1967</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>October 27, 1967</b> , and that death occurred at <b>2:20 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>C. H. Winnacott</b>		22b. DATE SIGNED <b>10/27/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M. D.</b>		22d. ADDRESS <b>Maryland</b> <b>Deer's Head State Hospital, Salisbury,</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-30-1967</b>	
23c. NAME OF CEMETERY <b>Presbyterian</b>		23d. LOCATION (City or Town) (County) (State) <b>Pocomoke City-Wor.-Md.</b>	
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 1 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14648

14658

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>	
c. LENGTH OF STAY IN 1b <u>33 days</u>		d. STREET ADDRESS <u>116 Choptank Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Robert</u> Middle <u>Alfred</u> Last <u>Lowe</u>		4. DATE OF DEATH Month <u>October</u> Day <u>30</u> Year <u>19 67</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/1/1901</u>
9. AGE (In years last birthday) yrs. <u>66</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oil Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert A. Lowe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-10-9035</u>	
17. INFORMANT <u>Mrs. Robert A. Lowe, Easton, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary thrombosis</u> DUE TO (b) <u>Generalized arteriosclerosis</u> stating the underlying cause lost. (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured left hip with surgery; carcinoma hypopharynx</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>9/27</u> , 19 <u>67</u> , to <u>10/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 30</u> , 19 <u>67</u> , and that death occurred at <u>12:12M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. H. Winnacott</u>		22b. DATE SIGNED <u>10/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. Winnacott, M. D.</u>		22d. ADDRESS <u>Maryland</u> <u>Deer's Head State Hospital, Salisbury</u>	
23a. BURIAL, CREMATION, REMOVAL, ETC. <u>Buried</u>	23b. DATE THEREOF <u>11/1/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Md.</u>
24. FUNERAL DIRECTOR <u>MURICE E. NEUNAM &amp; SON, Easton, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

14624

REPORT OF DEATH

14624

Name of Deceased		Date of Death	
Sex		Age	
Place of Birth		Date of Birth	
Occupation		Cause of Death	
Manner of Death		Place of Death	
Signature of Physician		Signature of Coroner	
Signature of Registrar		Signature of Witness	
Date of Report		Time of Report	



14650

## CERTIFICATE OF DEATH

14659

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. COUNTY <b>MD. SOMERSET</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>WESTOVER</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>19-2</b>	
3. NAME OF DECEASED (Type or print) <b>Frank S Matthews</b>		4. DATE OF DEATH <b>October 16 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>DEC. 26, 1894</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED CARPENTER</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>SHELLTOWN, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM V. MATTHEWS</b>		14. MOTHER'S MAIDEN NAME <b>LILLIE SMITH</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>MR. GERALD MATTHEWS</b>		Address <b>OWING MILLS, MD.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion of</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>left descending Coronary artery</b> DUE TO (c) <b>Arteriosclerosis (Cardiovascular) Dis</b> <b>4 yrs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Myocardial Insufficiency</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>9/30</b> , 19 <b>67</b> , to <b>10/10</b> , 19 <b>67</b> that (I) (we) last saw the deceased alive on <b>10/9</b> , 19 <b>67</b> , and that death occurred at <b>7:30</b> M., from causes and on the date stated above.			
22a. SIGNATURE <b>Rufuss Gardner Jr.</b> M.D.		22b. DATE SIGNED <b>10/26/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>RUFUSS GARDNER JR.</b>		22d. ADDRESS <b>MEDICAL CENTER, SALISBURY, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>10/14/1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MANOKIN PRES. CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCESS ANNE, MD.</b>	
24. FUNERAL DIRECTOR <b>LEVIN R. WILSON</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>	
ADDRESS <b>PRINCESS ANNE, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1-1-53

DEPARTMENT OF HEALTH

8-2-53

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14651

14660

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>401 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>Pine Street</b>	
3. NAME OF DECEASED (Type or print) <b>Hazel Omega McIntyre</b>		4. DATE OF DEATH Month <b>October</b> Day <b>4</b> Year <b>1967</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 23, 1908</b>
9. AGE (In years last birthday) yrs. <b>58</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerical</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Fuel Supply Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Marion Station, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles W. Howeth</b>		14. MOTHER'S MAIDEN NAME <b>Laura J. Dodson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-05-3185</b>	
17. INFORMANT <b>Charles W. Howeth - S. Somerset Ave. Crisfield, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>170X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of right breast with extensive metastasis</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>xx</del> (this hospital) attended the deceased from <b>Aug. 29, 1966</b> , to <b>Oct. 4, 1967</b> , that <del>x</del> (we) last saw the deceased alive on <b>Oct. 4, 1967</b> , and that death occurred at <b>8:55 A.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve</b>		22b. DATE SIGNED <b>10/4/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 7, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Episcopal Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Princess Anne, Md.</b>	
24. FUNERAL DIRECTOR <b>Bradshaw and Sons</b>		25a. REC'D BY REGISTRAR <b>Crisfield, Md</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 9 1967</b>	

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VR A15 (4)  
25M 1/67

14652

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14661

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 15 <b>40 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>604 Light Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>BATTIE</b> Middle <b>MIXON</b> Last		4. DATE OF DEATH Month <b>10</b> Day <b>23</b> Year <b>1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 12, 1899</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired- Inland Fish Comm.</b>		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) <b>Atlanta, Georgia</b>		13. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14. FATHER'S NAME <b>Jesse Mixon</b>		15. MOTHER'S MAIDEN NAME <b>Unknown ----- Rinkles</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes War I</b>		17. SOCIAL SECURITY NO. <b>214-07-1155</b>	
18. INFORMANT <b>Mrs. Lucille S. Mixon (Wife)</b> <b>604 Light Street, Salisbury, Maryland</b>		Address	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident - Left Hemiparesis</b> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Hypertensive arteriosclerotic heart disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 months</b> Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>September 13, 1967</b> to <b>October 23, 1967</b> , that (I) (we) last saw the deceased alive on <b>October 23, 1967</b> , and that death occurred at <b>9:50 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <i>C. H. Winnacott</i>		22b. DATE SIGNED <b>10/23/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 26, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Augusta, W. Virginia</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 26 1967</b>	
		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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## CERTIFICATE OF DEATH

14662

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Cecomica</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>660 W. Main St</b>	
3. NAME OF DECEASED (Type or print) <b>Baby</b>		4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>1967</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>C</b>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10-10-67</b>	
9. AGE (In years last birthday) <b>11</b>		10. IF UNDER 1 YEAR Months <b>11</b> Days <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico Co</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ALLEN CERRY</b>		14. MOTHER'S MAIDEN NAME <b>REMEMBRA NEAL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>JOAN BUNDICK</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) <b>Immaturity (740 Gms)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from <b>10/10</b> , 19 <b>67</b> , to <b>10/11</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10/11</b> , 19 <b>67</b> , and that death occurred at <b>12:45</b> PM, from causes and on the date stated above 22a. SIGNATURE <b>Dr. Anderson</b> 22b. DATE SIGNED <b>10/11/67</b> 22c. PHYSICIAN'S NAME (Type) <b>Dr. Anderson</b> 22d. ADDRESS <b>Salisbury, Md.</b> 23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>9-14-67</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b> 23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico</b> 24. FUNERAL DIRECTOR <b>West Sun. Home</b> 25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

Page 4 may be retained by the hospital or offending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14654

## CERTIFICATE OF DEATH

14663

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>3 wks</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>108 W. William St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARGUERITE Nelson</u> First Middle Last <b>5. SEX</b> <u>FEMALE</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF DEATH</b> <u>OCTOBER 1 1967</u> Month Day Year <b>9. AGE</b> (In years last birthday) <u>63</u> Yrs. <b>10. IF UNDER 1 YEAR</b> Months Days <b>11. IF UNDER 24 HRS.</b> Hours Min.			<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>NEW YORK</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				
<b>13. FATHER'S NAME</b> <u>William Guendalga</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Kathleen Smith</u>			<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No.</u> (If yes give war or dates of service) <b>16. SOCIAL SECURITY NO.</b> <u>UNKNOWN</u> <b>17. INFORMANT</b> <u>WALTER J. NELSON - SEE #2.</u> Address				
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> DUE TO (b) <u>Anemia, blood loss (type)</u> DUE TO (c) <u>Carcinomatosis (Primary in situ)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 weeks</u> <u>1 wk +</u> <u>12 mos.</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Sept 1, 1967</u> , to <u>October 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct. 1 1967</u> , and that death occurred at <u>7:01 P.M.</u> from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Rufus S. Gardner, Jr. M.D.</u> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>RUFUS S. GARDNER, JR.</u> <b>22d. ADDRESS</b> <u>MEDICAL CENTER, SALISBURY, MD.</u> <b>22b. DATE SIGNED</b> <u>10/1/67</u>			<b>23a. BURIAL, CREMATION REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>10/4/1967</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Woodlawn Cem.</u> <b>23d. LOCATION (City or town) (County) (State)</b> <u>Salisbury, Md.</u>				
<b>24. FUNERAL DIRECTOR</b> <u>Funeral Home - Salisbury, Md.</u> ADDRESS			<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u> <b>25b. REGISTRAR'S SIGNATURE</b> <b>DATE</b> <u>OCT 4 1967</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



100-222

REPORT OF DEATH

100-222

Name of Deceased		Date of Death	
John Doe		10/10/1950	
Age		Sex	
45		Male	
Race		Marital Status	
White		Married	
Occupation		Cause of Death	
Teacher		Heart Disease	
Place of Death		Date of Burial	
Home		10/15/1950	
Burial Place		Signature of Physician	
Cemetery		[Signature]	
Name of Undertaker		Signature of Coroner	
[Name]		[Signature]	
Address		Signature of Registrar	
[Address]		[Signature]	
City		Signature of Minister	
[City]		[Signature]	
State		Signature of Priest	
[State]		[Signature]	
County		Signature of Pastor	
[County]		[Signature]	
Zip		Signature of Rector	
[Zip]		[Signature]	



14655

## CERTIFICATE OF DEATH

14664

1. PLACE OF DEATH o. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Federal St.</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Clifton</b> Last <b>Nock</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 16, 1895</b>
9. AGE (In years last birthday) <b>72</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>19</b> Hours <b>67</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Agent</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Ins.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Snow Hill, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John L. Nock</b>		14. MOTHER'S MAIDEN NAME <b>Blanche Irwin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WWI</b>		16. SOCIAL SECURITY NO. <b>214-32 7123</b>	
17. INFORMANT <b>Mrs. Willye J. Nock</b>		Address <b>Snow Hill, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>4200</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10-5</b> , 19 <b>67</b> , to <b>10-5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-5</b> , 19 <b>67</b> , and that death occurred at <b>11 A</b> M, from causes on the date stated above.			
22a. SIGNATURE <b>Walter R. Allen</b>		22b. DATE SIGNED <b>10-5-67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Oct. 8, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mathematic Memorial Presbyterian</b>		23d. LOCATION (City or Town) (County) (State) <b>Snow Hill, Md.</b>	
24. FUNERAL DIRECTOR <b>Norman F. Harris</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 9 1967</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11061

INFORMED OF DEATH

11061

Washington

11061

11061

11061

11061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 22 hours after death.

1

14656

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14665

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		d. STREET ADDRESS <b>207 New York Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>Nancy</b> Middle <b>Blanche</b> Last <b>Payne</b>		4. DATE OF DEATH Month <b>October</b> Day <b>11</b> Year <b>19 67</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 19 1882</b>
9. AGE (In years lost birthday) <b>85</b> yrs.		10. IF UNDER 1 YEAR Months <b>85</b>	11. IF UNDER 24 HRS. Hours <b>85</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Greenbackville, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Eugene C. Payne</b>		14. MOTHER'S MAIDEN NAME <b>Esther Hancock</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-52-8107</b>	
17. INFORMANT <b>Roger W. Payne, Salisbury, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary and pulmonary edema</b> DUE TO (b) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>4201</b> DUE TO			INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture of pelvis, right pubis and ischium; diabetes mellitus.</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>9/12</b> , 19 <b>67</b> , to <b>10/11</b> , 19 <b>67</b> , that (I) (we) lost the deceased alive on <b>10/11</b> , 19 <b>67</b> , and that death occurred at <b>12:45</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. C. Mitchell, M.D.</b>		22b. DATE SIGNED <b>10/11/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. C. Mitchell, M. D.</b>		22d. ADDRESS <b>Deer's Head Hospital; Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Oct. 13, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Bensenville Meth.</b>	23d. LOCATION (City or Town) (County) (State) <b>Stockton, Md.</b>
24. FUNERAL DIRECTOR <b>William F. Thomas, Snow H. H., Md.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 16 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

VR A15 (4)  
25M 1/67



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
14657													
14666													
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> c. LENGTH OF STAY IN JB <b>Adm. in Id 9/30/67</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Peninsula General Hospital</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hebron</b> d. STREET ADDRESS <b>Walnut Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>LULA</b> Middle <b>BERTIE</b> Last <b>PHILLIPS</b>						4. DATE OF DEATH Month <b>October</b> Day <b>1</b> Year <b>19 67</b>							
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 8, 1889</b>		9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Shirt Factory</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Worcester County, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Henry Shockley</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Elizabeth Dickerson</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-09-2178</b>		17. INFORMANT Address <b>Mr. Oscar Lee Phillips (Husband) Box 477, Hebron, Maryland</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> 4201 DUE TO <b>Arteriosclerotic Coronary Artery Disease</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Severe congestive Heart failure</b> INTERVAL BETWEEN ONSET AND DEATH <b>Minutes Probably 45</b>													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20c. TIME OF INJURY Hour a.m. <b>19</b> p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Salisbury</b>		(County) <b>Wicomico</b>		(State) <b>Md.</b>			
21. I certify that (I) (this hospital) attended the deceased from <b>9/30/67</b> to <b>10/1/67</b> that (I) (we) last saw the deceased alive on <b>9/30/67</b> and that death occurred at <b>9 P.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>Dr. O. J. Burton</b>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>October 4, 1967</b>					
22c. PHYSICIAN'S NAME (Type) <b>Dr. O. J. Burton</b>						22d. ADDRESS <b>Medical Center, Salisbury, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>October 5, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>				23d. LOCATION (City, town or county) <b>Salisbury, Maryland</b>					
24. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>						ADDRESS <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 6 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hebron c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 111 Railroad Avenue		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hebron d. STREET ADDRESS 111 Railroad Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE EMMA PHIPPIN		4. DATE OF DEATH Month Day Year October 23 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 22, 1895
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wicomico County, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Fitzgerald		14. MOTHER'S MAIDEN NAME Alice English	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 212-10-2695	
17. INFORMANT Mr. Marion C. Phippin (Husband) 111 Railroad Ave., Hebron, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Arteriosclerotic Heart Disease</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH 5 yrs approx.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4/23/55 to Oct-23-67 that (I) (we) last saw the deceased alive on Oct-23-1967 and that death occurred at 10:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. David J. Gilmore		22b. DATE SIGNED October 25 1967	
22c. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		22d. ADDRESS Medical Center, Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1967	
23c. NAME OF CEMETERY OR CREMATORY Nelson Memorial Cemetery		23d. LOCATION (City, town or county) (State) Hebron, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE OCT 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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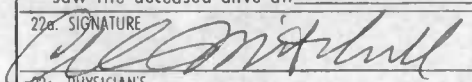

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>66 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>Eva</b> Last <b>PINKNEY</b>		4. DATE OF DEATH Month <b>10</b> Day <b>12</b> Year <b>1967</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-24-1901</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	9. AGE (In years last birthday) <b>66/65</b> yrs.
11. BIRTHPLACE (County & State, or foreign country) <b>Talbot Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Dan Cooper</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Stanley</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-18-4206</b>	
17. INFORMANT <b>Louvenia Cooper, R2, Box 8, Trappe, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bronchial pneumonia</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <b>Severe rheumatoid arthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o.m.</b> <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <b>(4)</b> (this hospital) attended the deceased from <b>August 7</b> , 1967, to <b>October 12</b> 1967, that <b>(4)</b> (we) lost saw the deceased alive on <b>October 12</b> 1967, and that death occurred at <b>9:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED <b>10/12/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. C. Mitchell, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury,</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10/16/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Trappe</b>	23d. LOCATION (City or Town) (County) (State) <b>Trappe, Talbot-Maryland</b>
24. FUNERAL DIRECTOR <b>Barbara L. Dashiell, 426 Dover Street, Easton, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 16 1967</b>	25b. REGISTRAR'S SIGNATURE 

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Item #9 Film #G393 10/18/67 ph

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DEPARTMENT OF DEFENSE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
Information taken from birth certificate			
14660			
CERTIFICATE OF DEATH			
14669			
1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Berlin</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>PO Box 312</b>	
3. NAME OF DECEASED (Type or print) <b>First Baby Middle Pitts Last</b>		4. DATE OF DEATH Month <b>October</b> Day <b>5</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-3-67</b>
9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico County, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Leroy Joseph Pitts</b>		14. MOTHER'S MAIDEN NAME <b>Patricia Elise Sumpter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Patricia Pitts Berlin Md.</b>		Address <b>PO Box 312</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Schredema</b> DUE TO <b>Prematurity (2# 11" 2oz)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b> <b>42' 25"</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Twin birth; other twin stillborn</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10/3</b> , 19 <b>67</b> to <b>10/5</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10/5</b> , 19 <b>67</b> , and that death occurred at <b>1230</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>DS Anderson</b>		22b. DATE SIGNED <b>10/5/67</b>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10-7-67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>New Bethel</b>		23d. LOCATION (City or Town) (County) (State) <b>Berlin - Worcester - Md</b>	
24. FUNERAL DIRECTOR <b>Louella B. Jolley Jersey Rd. #12 Salisbury, Md.</b>		25a. REC'D BY REGISTRAR <b>Oct 11 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14661

14670

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRUITLAND</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRUITLAND</u>		22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIZZIE GIBBS POPE</u>				4. DATE OF DEATH Month Day Year <u>OCT. 18 19 67</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 29, 1885</u> 87 yrs.		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PET SELF EMP</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC R. GIBBS</u>				14. MOTHER'S MAIDEN NAME <u>JULIA DAVIS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT Address <u>MR. MILTON POPE FRUITLAND MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> DUE TO (b) <u>generalized arteriosclerosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>8 hr.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/23, 1967</u> , to <u>10/18, 1967</u> , that (I) (we) last saw the deceased alive on <u>10/17, 1967</u> , and that death occurred at <u>3:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Robert T. Adkins</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>19 OCT 67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert T. Adkins</u>				22d. ADDRESS <u>FRUITLAND MD 21820</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/19/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		23d. LOCATION (City or Town) (County) (State) <u>BERLIN INDC MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage Berlin Md</u>				25a. REC'D BY REGISTRAR DATE <u>OCT 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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THE STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

14662

14671

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md. 21837</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs, Md</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mardela Springs, 22-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>ANNA</b> Middle <b>M.</b> Last <b>QUINN</b>		4. DATE OF DEATH Month <b>Oct.</b> Day <b>18</b> Year <b>19 67</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/16/1890</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Martin Co.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Rockhall, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Anton Gagalski</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>217-22-1598</b>		17. INFORMANT <b>Dr. Fred C. Quinn, husband, above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260X complications in preparation, with diabetes.</b> DUE TO (b) <b>low B.P. anemia</b> DUE TO (c) <b>diabetes</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <b>Diabetes - Acute</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <b>no</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. — p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov</b> , 19__, to __, 19__, that (I) (we) last saw the deceased alive on __, 19__, and that death occurred at __ M, from causes and on the date stated above.			
22a. SIGNATURE <b>Fred C. Quinn</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Fred C. Quinn</b>		22d. ADDRESS <b>Mardela Springs, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/21/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		25a. REC'D BY REGISTRAR <b>OCT 20 1967</b>	
ADDRESS <b>3331 Brehms Lane</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

155-1

14663

## CERTIFICATE OF DEATH

14672

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>5 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>Willards</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Vaughn E. RAYNE</b>		4. DATE OF DEATH Month Day Year <b>October 21 1967</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 23, 1920</b>
9. AGE (In years last birthday) yrs. <b>47</b>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Merchant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hardware</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Rayne</b>		14. MOTHER'S MAIDEN NAME <b>Manie Mitchell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>xx xx</b>		16. SOCIAL SECURITY NO. <b>213-14-1752</b>	
17. INFORMANT <b>Frances Rayne Willards, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Embolism</b> DUE TO (b) <b>Atrial Fibrillation</b> DUE TO (c) <b>Cardiomyopathy etiol. undet.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <b>12 hours.</b> <b>6 mo.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-14-67</b> , 19 to <b>10-21-67</b> , 19, that (I) (we) last saw the deceased alive on <b>10-21-67</b> , 19, and that death occurred at <b>8 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Joseph C. Fitzgerald</b>		22b. DATE SIGNED <b>10-22-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>Joseph C. Fitzgerald</b>		22d. ADDRESS <b>SALISBURY MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>	23b. DATE THEREOF <b>10/24/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant</b>	23d. LOCATION (City or Town) (County) (State) <b>Willards Maryland</b>
24. FUNERAL DIRECTOR <b>Peter Whaley Selbyville, Del.</b>		25a. REC'D BY REGISTRAR DATE <b>OCT 25 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>William A. Jones</b>			

STATEMENT OF WORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
14664		14673	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgely</u>	
c. LENGTH OF STAY IN 1b <u>2 mos.-23days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>Deer's Head State Hospital</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anderson</u> Middle <u>Steven</u> Last <u>Redden</u>		4. DATE OF DEATH Month <u>October</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 1, 1885</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>owner</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ORLANDO REDDEN</u>		14. MOTHER'S MAIDEN NAME <u>SARAH E. (unl-nour)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>14664</u>	
17. INFORMANT <u>MARION REDDEN RIDGELY MD</u>		Address <u>Deer's Head State Hospital, Salisbury, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pnuemonia</u> DUE TO <u>6000</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pyelonephritis</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Chronic Hypertrophic Osteoarthritis - Chronic Emphysema</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 6, 1967</u> , to <u>October 29, 1967</u> , that (I) (we) last saw the deceased alive on <u>October 29, 1967</u> , and that death occurred at <u>1030</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>C. H. Winnacott</u>		22b. DATE SIGNED <u>10/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. H. Winnacott, M.D.</u>		22d. ADDRESS <u>Deer's Head State Hospital, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov 1, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Denton</u>	23d. LOCATION (City or Town) (County) (State) <u>DENTON MD</u>
24. FUNERAL DIRECTOR <u>Charles Moore Denton Md</u>		25a. REC'D BY REGISTRAR <u>NOV 3 1967</u>	
ADDRESS <u>Charles Moore Denton Md</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

14665

CERTIFICATE OF DEATH

14674

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b>		c. LENGTH OF STAY IN lb <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Willards</b> 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>XX</b>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Stella Mae Cooper Routzahn</b>			4. DATE OF DEATH Month <b>Oct</b> , Day <b>11</b> , Year <b>1967</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 11, 1896</b>	9. AGE (In years last birthday) yrs. <b>71</b>	IF UNDER 1 YEAR Months <b>3</b> Days <b>7</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>George Bratten</b>			14. MOTHER'S MAIDEN NAME <b>Mariah</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>XX</b> (If yes give war or dates of service) <b>XX</b>		16. SOCIAL SECURITY NO. <b>No #</b>		17. INFORMANT <b>Edward Cooper Willards, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic myxoidosis</b> DUE TO <b>Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 <b>day of death</b> , that (I) <b>we</b> last saw the deceased alive on <b>10-9</b> <b>1967</b> , and that death occurred at <b>9:00</b> A.M. from causes and on the date stated above.					
22a. SIGNATURE <b>Frank Lewis</b>			22b. DATE SIGNED <b>10-12-67</b>		22c. PHYSICIAN'S NAME (Type) <b>Frank Lewis</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>10/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cooper</b>
24. FUNERAL DIRECTOR <b>Peter Whaley</b>			25a. REC'D BY REGISTRAR DATE <b>OCT 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Judge</b>

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ESTIMATE OF LEAD

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14665

14675

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>Quantico</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Edwin</b> Last <b>Sample</b>		4. DATE OF DEATH Month <b>10-22-67</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>C</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-29-67</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>infant</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Salisbury, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Leroy Sample</b>		14. MOTHER'S MAIDEN NAME <b>Shirley Reddick Quantico, Md.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Leroy Sample Quantico, Maryland</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>492X Intestinal Perforation</b> IMMEDIATE CAUSE (a) <b>Due to</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Due to</b> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <b>SUDDEN DEATH IN INFANCY</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>409 Camden Ave. Salisbury, Md.</b>		22. DATE SIGNED <b>10-23-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/24/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Green Arces Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury Wicomico Md.</b>	
24. FUNERAL DIRECTOR <b>Clinton F. Stewart</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>OCT 25 1967</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed and completely filled in by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14667

14676

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>706 - 4th St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Mattie</u> Middle <u>Edna</u> Last <u>Schoolfield</u>		4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 19, 1903</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>19</u> Hours <u>67</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Schoolfield</u>		14. MOTHER'S MAIDEN NAME <u>Mary Schoolfield</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-07-4761A</u>	
17. INFORMANT <u>Louvenia Phillips</u>		Address <u>Pocomoke City, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subtotal coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fatty Infiltration of liver</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>9-30-</u> , 19 <u>67</u> , to <u>10-1</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>10-1</u> , 19 <u>67</u> , and that death occurred at <u>10:35</u> AM, from causes and on the date stated above.			
22a. SIGNATURE <u>James R. Cyppe</u>		22b. DATE SIGNED <u>10-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James R. Cyppe</u>		22d. ADDRESS <u>Medical Center Salisbury Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10-7-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. James Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Pocomoke Wor. Md.</u>
24. FUNERAL DIRECTOR <u>Samuel Stange</u>		25a. REC'D BY REGISTRAR <u>OCT 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



14668

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>short</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Manford Franklin Shockley</b>		4. DATE OF DEATH Month <b>10</b> Day <b>26</b> Year <b>67</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-2-1907</b>
9. AGE (In years lost birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months <b>19</b> Days <b>19</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>laborer</b>	
11. BIRTHPLACE (State or foreign country) <b>Wicomico Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur G. Shockley</b>		14. MOTHER'S MAIDEN NAME <b>Maggie Wells</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216 18 8877</b>	
17. INFORMANT <b>Lura W. Shockley</b>		Address <b>Pittsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b> EXAMINER'S NAME (Type) <b>1409 Camden Ave. Salisbury, Md.</b>		22. DATE SIGNED <b>10-27-67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>10/28/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Farlow's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>rural Pittsville, Md.</b>	
24. FUNERAL DIRECTOR <b>J. Wells Wells</b> ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>OCT 31 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Wells Wells</b>		25c. REGISTRAR'S SIGNATURE <b>J. Wells Wells</b>	

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Ann Arbor, Michigan 48106

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
14669 CERTIFICATE OF DEATH 14678									
1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>1 mon.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wicomico Nursing Home</u>					d. STREET ADDRESS <u>Belmont Ave</u> <u>Pemberton Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CARL HENRY SMITH, SR.</u>					4. DATE OF DEATH Month Day Year <u>10 18 19 67</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Aug. 10, 1884</u>		9. AGE (In years lost birthday) yrs. <u>83</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Truck</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland -- Wicomico</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Smith</u>					14. MOTHER'S MAIDEN NAME <u>MARIA HAYMAN</u> <u>Unknown</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO.</u>			16. SOCIAL SECURITY NO. <u>218-34-7703</u>		17. INFORMANT Address <u>Dr. Wm. B. Smith Salisbury, Maryland</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemiparesis</u> DUE TO <u>Stroke</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <u>Arteriosclerosis</u> (c)								INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> , 19 <u>67</u> , to <u>10/19</u> , 19 <u>67</u> that (I) (we) lost saw the deceased alive on <u>10/18</u> , 19 <u>67</u> , and that death occurred at <u>3:40</u> M. from causes and on the date stated above.									
22a. SIGNATURE <u>William B. Smith</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/19/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>William B. Smith M.D.</u>				22d. ADDRESS <u>402 S. Division St., Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/21/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wico. Mem. Park</u>			23d. LOCATION (City or Town) (County) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTOR <u>George C. Heif</u>				ADDRESS <u>Salisbury, Maryland</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN lb <b>4 Days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>402 Woodcrest</b>	
3. NAME OF DECEASED (Type or print) <b>JOHN WOLFE</b>		4. DATE OF DEATH Month <b>October</b> Day <b>15</b> Year <b>19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-12-1891</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Salesman</b>	9. AGE (In years last birthday) yrs. <b>76</b>
11. BIRTHPLACE (County & State, or foreign country) <b>Kingston, New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Stout</b>		14. MOTHER'S MAIDEN NAME <b>Mary Wolfe</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-10-9664</b>	
17. INFORMANT <b>Mrs. Blossom C. Stout, See Sec.2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured aortic abdominal aneurysm.</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Atherosclerosis of aorta.</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 M.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>October 12, 1967</b> to <b>October 15, 1967</b> , that (I) (we) lost saw the deceased alive on <b>October 15, 1967</b> , and that death occurred at <b>3:30 A.M.</b> from causes on and on the date stated above.			
22a. SIGNATURE <b>N. W. Todd</b>		22b. DATE SIGNED <b>10-15-1967</b>	
22c. PHYSICIAN'S NAME (Type) <b>Nevins W. Todd</b>		22d. ADDRESS <b>Medical Center - Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-18-1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Manokin Presbyterian Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Princess Ann, Maryland</b>
24. FUNERAL DIRECTOR <b>Hill Funeral Home Salisbury, Maryland</b>		25a. REC'D BY REGISTRAR <b>OCT 17 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, it must be approved by the Director. Page 1, 2, and 3 must be filed with the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained by the funeral director. Page 6 should be used as a burial-transit permit. File pages 1 and 2 with the State Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Worcester</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY in 1b (If outside corporate limits, write RURAL and give nearest town) <u>32-2</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hosp.</u> <u>Marguerite Ellen Truitt</u>				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>R. F. Dr #2 Box 22</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Marguerite Ellen Truitt</u>				4. DATE OF DEATH Month <u>October</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>7</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>February 8 1904</u> 63 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Purnell</u>				14. MOTHER'S MAIDEN NAME <u>Georgianna Harmon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give year or dates of service)</u>				16. SOCIAL SECURITY NO. <u>Ruby Mills - Snow Hill Md, Rt #1 Box 87B</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting Aneurysm Thoracic Aorta</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized Arterio Sclerosis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Philip A. Insley</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Philip A. Insley</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DATE SIGNED <u>10-18-67</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>10-21-67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER Methodist</u>	
				22d. LOCATION (City, town, or country) <u>Snow Hill</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR <u>Loretta B. Jolley</u>				ADDRESS <u>Jessy Rd. Rt #2 Salisbury Md.</u>		24a. REC'D BY REGISTRAR <u>OCT 20 1967</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur J. Insley</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wicomico Nursing Home</u>						d. STREET ADDRESS <u>405 Oxford St.</u>					
3. NAME OF DECEASED (Type or print) First <u>Josephine</u> Middle <u>Ellen</u> Last <u>Tyler</u>						4. DATE OF DEATH Month <u>October</u> Day <u>5</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 24, 1915</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Turner</u>						14. MOTHER'S MAIDEN NAME <u>Alice Parker</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>231-36-7551</u>		17. INFORMANT Address <u>Raymond Turner Georgetown, Del.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>203X</u> DUE TO <u>multiple myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>pathologic fracture rt. femur</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7/14</u> , 19 <u>67</u> , to <u>10/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/4</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> AM, from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/7/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10-11-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bayside Cem.</u>				23d. LOCATION (City, town or county) (State) <u>Anancock Va.</u>	
24. FUNERAL DIRECTOR <u>[Signature]</u>						ADDRESS <u>New Church, Va.</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
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14673

## CERTIFICATE OF DEATH

14683

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>		d. STREET ADDRESS <b>602 Walnut Street</b>	
3. NAME OF DECEASED (Type or print) First <b>GARLAND</b> Middle <b>CLINTON</b> Last <b>WESSELLS</b>		4. DATE OF DEATH Month <b>October</b> Day <b>9</b> Year <b>1967</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 7, 1896</b>
9. AGE (In years last birthday) yrs. <b>71</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Sales</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Accomack County, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Wessells</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-05-2014</b>	
17. INFORMANT <b>Mrs Eva R. Wessells, Maryland</b>		Address <b>Pocomoke City,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>lung pneumonia</b> DUE TO (c) <b>1621</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>10-9</b> , 19 <b>67</b> to <b>10-7</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10-7</b> , 19 <b>67</b> , and that death occurred at <b>1:55</b> P.M. from causes and on the date stated above.			
22a. SIGNATURE <b>N.W. Todd</b>		22b. DATE SIGNED <b>10-9-67</b>	
22c. PHYSICIAN'S NAME (Type) <b>N.W. Todd</b>		22d. ADDRESS <b>Medical Center, Salisbury, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>10-12-1967</b>	23c. NAME OF CEMETERY OR CREMATOR <b>Bethany Methodist</b>	23d. LOCATION (City or Town) (County) (State) <b>Pocomoke - Wor. - Md.</b>
24. FUNERAL DIRECTOR <b>Robert H. Watson</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Pocomoke City, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

14684

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. LENGTH OF STAY IN 1b <b>1 yr</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Wicomico</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Peninsula General Hospital</b>						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) <b>Willie</b> First Middle Last <b>Williams</b>						4. DATE OF DEATH <b>Oct. 8</b> Month Day Year <b>19 67</b>					
5. SEX <b>M</b>		6. COLOR OR RACE <b>C</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-15-14</b>		9. AGE (In years last birthday) <b>53</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Labor</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Wicomico Co</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John W. Williams</b>						14. MOTHER'S MAIDEN NAME <b>Angeline Roberts</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>20-28-4331</b>		17. INFORMANT <b>Classic Williams</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fibrillation</b> 4341 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiac Insufficiency</b> DUE TO (c) <b>Congestive Heart Failure</b>										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>10/6</b> , 19 <b>67</b> , to <b>10/8</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>10/8</b> , 19 <b>67</b> , and that death occurred at <b>10:30 PM</b> , from causes and on the date stated above.											
22a. SIGNATURE <b>W. B. Smith</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>10/19/67</b>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>10-14-67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury Wicomico</b>			
24. FUNERAL DIRECTOR <b>West</b> ADDRESS <b>Green Home</b>						25a. REC'D BY REGISTRAR DATE <b>OCT 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cat-bomb papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

14675

14685

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Caroline</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg</b>	
c. LENGTH OF STAY IN lb <b>22 days</b>		d. STREET ADDRESS <b>--</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deer's Head State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>RICHARD JAMES WILLOUGHBY</b>		4. DATE OF DEATH Month Day Year <b>10 18 1967</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. B. DATE OF BIRTH <b>Aug. 5, 1894</b>
9. AGE (In years lost birthday) <b>73 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>sawmill and canning factory work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Caroline Co. Md.</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Nathan Willoughby</b>		14. MOTHER'S MAIDEN NAME <b>Mary Newton</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>222-01-6275</b>	
17. INFORMANT <b>Andrew Willoughby</b>		Address <b>Federalsburg, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <b>Retroperitoneal lymphosarcoma</b> <b>2001</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3-4 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>September 26, 1967</b> , to <b>October 18, 1967</b> , that (I) (we) last saw the deceased alive on <b>October 18, 1967</b> , and that death occurred at <b>4:10 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>L. V. Maldve, M. D.</b>		22b. DATE SIGNED <b>10/18/67</b>	
22c. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22d. ADDRESS <b>Deer's Head State Hospital, Salisbury, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>10/18/67</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bloomery Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Federalsburg, Md.</b>	
24. FUNERAL DIRECTOR <b>Charles Judge</b>		25a. REC'D BY REGISTRAR <b>OCT 24 1967</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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[Faint, mostly illegible text and markings covering the page, including what appears to be a large, faint signature or stamp in the center.]



FOR STATE  
HEALTH DEPT.

14676

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14686

1. PLACE OF DEATH a. COUNTY <b>Wicomico</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hebron</b>		c. LENGTH OF STAY IN 1b <b>Baltimore</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Corner Lillian &amp; Main Streets</b>		d. STREET ADDRESS <b>617 W. 40th Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>THOMAS NORWOOD WILSON</b>		4. DATE OF DEATH Month Day Year <b>October 28 19 67</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 19, 1899</b>
9. AGE (In years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Physician</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Roy Wilson</b>		14. MOTHER'S MAIDEN NAME <b>Cora V. Nelson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-34-0676A</b>	
17. INFORMANT <b>Mrs. Frances A. Wilson (Wife)</b> Address <b>617 W. 40th Street, Baltimore 11, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>  <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Earl L. Royer, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
ADDRESS <b>409 Camden Ave., Salisbury, Md.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22. DATE SIGNED <b>October 30/1967</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 1, 1967</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>	
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>OCT 31 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

8778

*John L. Gage*

## CERTIFICATE OF DEATH

14687

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>WILLIAMS</u>	
3. NAME OF DECEASED (Type or print) <u>CALVIN BUDD WIMBROUGH</u>		4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 18, 1904</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WELDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN BUSINESS</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES S. WIMBROUGH</u>		14. MOTHER'S MAIDEN NAME <u>LILLIAN TYRE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MRS. C.B. WIMBROUGH</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331X Intracerebral hemorrhage</u> DUE TO (b) <u>Hypertension</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cardiac arrhythmia - atrial fibrillation and premature vent. contr.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>10-22</u> , 19 <u>67</u> , to <u>10-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-23</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> P.M., from causes and on the date stated above.	
22a. SIGNATURE <u>Thomas Paul Bighy</u>		22b. DATE SIGNED <u>10-23-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/27/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City or Town) (County) (State) <u>BERLIN W.D. MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burbage Berlin Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 26 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Glenn Jones</u>		25c. REGISTRAR'S NAME <u>Glenn Jones</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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